CHILD AND ADOLESCENT HISTORY FORM

CONFIDENTIALITY

All of the information that you provide below is strictly confidential. It cannot be released to anyone without your specific written permission.

REQUEST FOR OTHER INFORMATION

In addition to filling out this lengthy but important form, PLEASE PROVIDE US WITH COPIES OF ALL PREVIOUS EVALUATIONS, REPORTS, PSYCHOLOGICAL TESTING, MEDICAL RECORDS, SCHOOL RECORDS, AND REPORT CARDS, ETC.

DIRECTIONS

This **HISTORY FORM** is the "cornerstone" of your child's clinical record. Therefore, we ask that you take as much time as you need to complete it. Please double check information you are unsure of, before completing form.

DATES: When dates are asked for, please give the "year" and if possible, the "month". "Exact" date are needed (unless you already know them)

QUESTION TYPES: We are using several types, or "formats" for questions: "circle the answers", "fill in the blanks", "written answers". Please complete these as best you can, BUT ALWAYS FEEL FREE TO ADD AS MUCH INFORMATION AS YOU LIKE, even if there does not seem to be a place for it.

BLANKS: Please do not leave any answer blank. Instead, please mark "none " or "n/a" (for not applicable), or "?" if you don't know the answer. This way we can tell whether you accidentally forgot to answer something versus you didn't know that answer.

THANK YOU FOR YOUR PATIENCE AND YOUR EFFORT

TODAY'S DATE: _____

CHILD:

FULL NAME:_____

AGE:_____ BIRTHDATE:_____ BIRTHPLACE:_____

SEX:_____ETHNIC ORIGIN (RACE):_____

HOME ADDRESS:_____

_____

HOME PHONE:_____

PERSON COMPLETING FORM:

NAME:_____

RELATIONSHIP TO CHILD:_____

REFERRAL SOURCE:

Please circle all that apply:

Professional Insurance Company Managed Care Company Friend Self

Name of Referral Source:_____

Address of Referral Source:_____

_____

Phone of Referral Source:_____

Please describe below how your referral to us came about:

Would you and/or the Referral Source like us to send a report?

Yes / No

(If so, please make sure to sign a "release of information form")

CHILD INFORMATION

GENERAL:

CHILD HAND PREFERENCE is (circle one): Right Left Ambidextrous

Has your child had PROBLEMS WITH (please circle items that apply):

SPEECH VISION HEARING NONE

If yes, please describe below:

Does your child suffer from any PHYSICAL HANDICAPS? Yes / No

If yes, please describe below:

BIRTH ORDER: In which order was your child born? (circle one)

First Second Third Other:_____

How many full siblings does this child have? _____

HOME:

Child is presently LIVING WITH (please circle ALL that apply):

Natural Mother Natural Father Stepmother Stepfather

Adoptive Mother Adoptive Father Foster Mother Foster Father

Other

Also: Please list names, ages, and relationship to child, of ALL persons with whom the child is currently living:

	NAME	AGE	RELATIONSHIP
1.			
2.			
3.			
4.			
5.			

Is home (please circle one): Owned or Rented

What type of housing does child live in? (please circle one)

House Apartment Trailer Townhome

How long has child lived there?_____

CHILD's LEGAL GUARDIAN(s), CUSTODY, VISITATION, ETC. :

NAME(S) of child's legal guardian(s)_____

_____

CUSTODY: Who has custody of this child?_____

_____

VISITATION: Please provide below, the specifics of "visitation" rights, if applicable:

BIOLOGICAL (NATURAL) PARENTS:

Name of child's biological father:_____

Name of child's biological mother:_____

OTHER ADULTS INVOLVED:

Non-residential adults involved with this child on a regular basis: (Please list regular babysitters, daycare staff, family members (outside of home, etc., who have regular contact with your child))

	NAME	AGE	RELATIONSHIP
1.			
2.			
3.			
4.			
5.			

SCHOOL:

Is child currently in school? Yes / No

Child's current or most recent school:_____

_____

Child's current or most recent grade level in school:_____

_____

Special school classes or placement (if any):_____

_____

Number of children in your child's class(es):_____

_____

School phone number:_____

Address of school:_____

Name of child's primary teacher(s):_____

Can we contact your child's teacher(s) for information regarding your child's school performance? Yes / No

Name of child's guidance counselor (if any):_____

ACTIVITIES:

Please list sports, clubs, hobbies, etc. that child is currently involved with, and/or is "good at", if any:

1.

2.

3.

4.

5.

YOUR MAIN CONCERNS:

DESCRIPTION:

In the space below, please describe <u>as specifically as possible</u> the child's major problems which have led you to seek consultation with us at this time:

PROBLEM LIST, IN PRIORITY ORDER:

Please list these problems below, starting with the MOST severe, and ending with the LEAST severe:

1.

2.

3.

4.

5.

WHEN PROBLEMS FIRST NOTICED:

When did you first notice these problems? (Please give a general date for each problem number):

	PROBLEM #	DATE FIRST NOTICED
1.		
2.		
3.		
4.		
5.		

PROBLEM "TRIGGERS"

Have you noticed that there is any particular situation or setting that makes your child's problems better or worse? (For example, if the child has terrible problems at school and none at home, or vice versa, etc.) Please describe in detail, but please refer to the problem number.

SPECIFIC PROBLEM AREA LIST:

Please circle the following area of concern that apply to your child:

- School Behavior
- School Emotional Problems
- School Grades
- School Peer Relations
- Home Behavior
- Home Emotional Problems
- Home Family Relations
- Home Neighborhood Peer Relations
- Legal Problems
- Other

PROBLEM CAUSES, FACTORS:

What do you, personally, believe to be the most important factors causing these problems, or th have "set them off?" (Please describe.)

RELATED STRESSES AND CHANGES:

Have there been any family changes or difficulties (such as a new baby, divorce, legal problems, etc.) which may be related to these problems? Yes / No

If yes, please describe below:

WHY NOW?

What about your current situation has led you to seek a consultation at this particular time, rather than later or earlier? (For instance, has something "terrible" happened, or has your child's problem simple "gone on for too long", etc.?)

PAST OPINION:

What have you been told in the past about the cause of these problems, and about your child's potential?

YOUR MAJOR GOALS FOR EVALUATION AND TREATMENT:

Please list your MAJOR GOALS for this child, i.e., what SPECIFICALLY do you hope that evaluation and treatment will accomplish for your child? Please be as specific as possible. Please list your MOST IMPORTANT goals first and least important last.

1.

2.

3.

4.

5.

EFFECT ON FAMILY:

How have your child's difficulties affected your family?

Who in the family has been most affected?

PAST MENTAL HISTORY

CURRENT THERAPIST:

Please list all mental health professionals currently working with your child AND FOR HOW LONG your child has worked with them, (include: social workers, guidance counselors, psychologists, psychiatrists, etc.)

	THERAPIST	**DATE BEGAN**
1.		
2.		
3.		

CURRENT TREATMENTS:

Please list the current "treatments" each therapist is using, (include "talking therapy", family therapy, parent training, etc.)

	TYPE OF TREATMENT
1.	
2.	
3.	

PAST THERAPISTS AND TREATMENTS:

Please list all therapists your child has seen in the <u>past</u>, and the types of treatments your child received from each. When did your child see them?

	THERAPIST	**DATE BEGAN**	**DATE ENDED**	**TYPE OF TREATMENT**
1.				
2.				
3.				

PAST PSYCHIATRIC HOSPITALIZATIONS, "RESIDENTIAL PLACEMENT", ETC. :

For each, please list name of facility, location, dates the child was there, as well as the attending psychiatrist, the official "diagnosis", and the treatments used:

	NAME OF FACILITY	LOCATION	DATES THERE
1.			
2.			
3.			

	FACILITY #	PSYCHIATRIST NAME	DIAGNOSIS	TREATMENT TYPE
1.				
2.				
3.				

PAST EVENTS:

Please circle, and give details of the following, if applicable:

- Physical Abuse
- Sexual Abuse
- Psychological Abuse
- Neglect
- Past Suicide Attempts
- Whether child has ever severely harmed persons, property, or animals

PAST MEDICAL HISTORY

CURRENT PRIMARY PHYSICIAN:_____

Child's current pediatrician or family physician:_____

How long has this physician worked with your child?_____

Address:_____

Phone:_____

Date of last office visit:_____

What was this visit for?_____

Date of last physical examination:_____

Please list your child's current medical problems, if any, this physicial is treating:

1.

2.

3.

OTHER CURRENT PHYSICIANS:

Please list other physicians who currently treat your child, and why:

	PHYSICIAN	PROBLEM TREATED
1.		
2.		

PAST PHYSICIANS:

Please list physicians (names, dates, and locations) who have treated your child in the past:

	PHYSICIAN	DATES	LOCATION
1.			
2.			
3.			

ALLERGIES:

Does your child have any allergies? Yes / No

If yes, please specify below what your child is allergic to, AND please also describe your child's "allergic reaction" to each:

	MEDICATION ALLERGIES	REACTION
1.		
2.		
3.		

	FOOD ALLERGIES	REACTION
1.		
2.		
3.		

	OTHER ALLERGIES	REACTION
1.		
2.		
3.		

CURRENT MEDICATIONS:

Please list ALL MEDICINES your child is currently taking, and the PHYSICIAN who prescribes them.

	MEDICINE	PRESCRIBING PHYSICIAN
1.		
2.		
3.		

PAST MEDICATIONS:

Please list all of those medicines, (and the physician who prescribed them), your child took previously that were for the treatment of a mental health problem, or a serious medical problem:

	MEDICINE	PRESCRIBING PHYSICIAN
1.		
2.		
3.		

SURGERIES:

Please list all surgeries, if any, your child has had. Please note WHEN, WHERE, AND WHY your child had these surgeries.

	SURGERY	DATE	LOCATION	REASON
1.				
2.				

HOSPITAL STAYS:

Please list all hospital stays your child has had. Please note the ATTENDING PHYSICIAN, WHEN, WHERE AND WHY your child was placed in the hospital.

	HOSPITAL	DATES	LOCATION	PHYSICIAN	REASON
1.					
2.					

MEDICAL PROBLEMS:

Please circle all of the following medical problems that have affected your child. Please note ANY IMPORTANT DETAILS, and the AGE when the incident or illness occurred.

PROBLEM	AGE	DETAILS
Childhood Diseases		
Mumps		
Measles		

Chicken Pox		
German Measles		
Strep Throat		
Scarlet Fever		
Seasonal Allergies		
Mononucleosis		
Whooping Cough		
Tuberculosis		
Other infections		
Head Injuries		
Loss of Consciousness or Blackouts		
Convulsions (Seizures or “fits”)		
Coma		
Persistent High Fever		
Meningitis or Encephalitis		
Headaches		
Migraine Headaches		
“TMJ” syndrome		
Serious Accidents		
Broken Bones (fractures)		
Frequent Ear Infections		
“Ear Tubes?” (myringotomy tubes)		
Severe Acne		
Asthma		
Lung Problems		
Stomach Problems		
Frequent Stomachaches		
Diarrhea		
Constipation		
Heart Problems		
Heart Murmurs		
Ventral Septal Defect (hole in heart)		
Mitral Valve Prolapse		
Kidney Problems		
Diabetes		
Frequent Bladder Infections		
Poisoning		
Lead or Mercury Exposure		
Menstrual History (if applies)		
Weak ankles, knees, elbows		
Other orthopedic problems		

OTHER MEDICAL PROBLEMS:

LABS AND MEDICAL TESTS

SPECIFIC TESTS:

Specifically, please circle any of the test below your child has undergone in the past, and also list WHEN and WHERE those tests were done, and whether the RESULTS were normal or abnormal:

TEST	DATE	LOCATION	RESULTS
EKF (electrocardiogram heart tracing)			
EEG (brain wave test)			
CT Scan (Special X-ray of the brain)			
MRI Scan (Special "magnetic" brain scan)			

OTHER TESTS:

Please list date and results of any OTHER lab test or other studies your child has undergone in the past, especially in the last 1-2 years:

	TEST NAME	DATE	LOCATION	RESULTS
1.				
2.				
3.				

FAMILY HISTORY

Please list ALL of your child's biological ("blood") relatives who have suffered from ANY of the following. In particular, please MAKE SURE to think about whether any of the following problems have affected the child's PARENTS, SIBLINGS, GRANDPARENTS, UNCLES, AUNTS, COUNSINS:

PROBLEM	RELATIVES AFFECTED
Heart Disease	
Diabetes (blood sugar)	
High Blood Pressure	
Glaucoma	
Medication Allergies	
Problems with attention, hyperactivity, and impulse control as a child	
Problems with aggression, defiance, oppositional behavior as a child	
Suffered Sexual Abuse	

Suffered Physical Abuse	
Formal “Learning Disabilities”	
Problems with reading, spelling, math	
Did not graduate from high school	
Severe school academic problems	
Severe school behavior problems	
“Nerve” problems	
Use of “nerve” pills	
“Nervous breakdown”	
Tics or Tourette’s Disorder	
Alcohol Abuse	
Drug abuse	
Severe depression	
Severe anxiety	
Schizophrenia	
Manic-Depression	
Mental Retardation	
Suicide Attempts or completions admission to a psychiatric or “state” hospital	
Anti-social behavior	
Legal problems (“problems with the law”)	
Arrests	
Convictions	
Violent Behavior	

SOCIAL HISTORY

PARENTS:

TO BE ANSWERED BY MOTHER:

(The child’s current “mother figure” should complete this section. Please also complete this same information, (to the side), on the child’s biological mother” if different from child’s current “mother figure”.):

Name:_____

Age:_____ Date of Birth:_____ Highest Grade Completed:_____

Place of Birth:_____ Where did you grow up:_____

Occupation:_____ Current Employer:_____

How long have you been with your present employer:_____

Ages of Brothers:_____ Ages of Sisters:_____ Medical Problems:_____

PRIOR MARRIAGES, if any:

Please give Name of ex-husband(s) and dates of prior marriages if any:

	NAME	DATES
1.		
2.		
3.		

What are your feelings about your parents and your childhood?

What are your future career and/or educational plans?

TO BE ANSWERED BY FATHER:

(The child's current "father figure" should complete this section. Please also complete this same information. (to the side), on child's "biological" father, if different from child's current "father figure"):

Name:_____

Age:_____ Date of Birth:_____ Highest Grade Completed:_____

Place of Birth:_____ Where did you grow up:_____

Occupation:_____ Current Employer:_____ Phone:_____

How long have you been with your present employer:_____

Ages of Brothers:_____ Ages of Sisters:_____ Medical Problems:_____

PRIOR MARRIAGES, if any:

Please give name of ex-wife(s) and dates of prior marriages if any:

	NAME	DATES
1.		
2.		
3.		

What are your feelings about your parents and your childhood?

What are your future career and/or educational plans?

TO BE ANSWERED BY BOTH PARENTS:

How would you describe your marriage:

In your marriage, what do you disagree about?

What type of discipline do you use for your children and how does it work?

What are your future hopes and plans for your family?

MOVES:

Please list all family moves since birth of this child, and dates:

	MOVE	**DATE**
1.		
2.		
3.		

SCHOOL HISTORY:

GRADE PROBLEM BEGAN:

In WHAT GRADE did your child FIRST have a problem, if any? _____

SPECIFIC SCHOOL CONSEQUENCES:

Please circle any of the following consequences by your child, and HOW MANY TIMES and in WHAT GRADE it occurred:

CONSEQUENCE	NUMBER OF TIMES	WHICH GRADES?
Referrals		
In-School Suspension		
Suspended from Riding the Bus		
Suspended from school to home		
Expelled from school		

SCHOOLS ATTENDED:

Please list all schools that your child has attended:

GRADE	NAME OF SCHOOL	LOCATION
Nursery		
(Headstart)		
Preschool		
Kindergarten		
Grade 1		
Grade 2		
Grade 3		
Grade 4		
Grade 5		
Grade 6		
Grade 7		
Grade 8		
Grade 9		
Grade 10		
Grade 11		
Grade 12		

REPEATS:

Did your child repeat any grade? Yes / No

Which Grade(s)?_____

Why?_____

SPECIAL CLASSES OR PROGRAMS:

Has your child ever been in any special educational program? Please circle those that apply, and fill in the grades your child was placed in the program, and whether program was full-time or part-time:

PROGRAM	WHICH GRADE(S)	PART-TIME/FULL-TIME
Learning Disabled		
Emotionally Handicapped		
Behaviorally Disabled		
Speech/Language Disabled		
Mental Retardation		
Other		

GRADES AND BEHAVIOR:

Please list your child's average grade (A-F) and average behavior (good, average, poor) for each year in school:

GRADE	AVERAGE GRADE (A-F)	BEHAVIOR (GOOD, AVERAGE, POOR)
Nursery School		
Kindergarten		
Grade 1		
Grade 2		
Grade 3		
Grade 4		
Grade 5		
Grade 6		
Grade 7		
Grade 8		
Grade 9		
Grade 10		
Grade 11		
Grade 12		

SCHOOL TESTING:

Please circle and give the grade in which any of the following testing or evaluations were provided for your child by the school:

TEST	GRADE
I.Q. Testing	
Learning Disability Testing	
Psychological Testing	
Speech/Language Testing	
Vision Testing	
Hearing Testing	
Other	

SCHOOL SERVICES:

Please circle and give the grade(s), during which the school provided any of the following services for your child, and the names of the professionals who provided those services:

SERVICE	GRADE(S)	NAMES
Psychologist		
Guidance Counselor		
Speech/Language Therapy		
Tutors		
Other		

PEERS:

Do you approve of your child's friends? Yes / No

Why? _____

Does your child have many friends? _____

Does your child seek friendship with peers? _____

Do peers seek out your child for friendship? _____

Please briefly describe any PRBLEMS your child has with PEERS:

DRUG USE:

Please circle any of the following substances used by your child, and describe any KNOWLEDGE OR SUSPICION you may have about whether your child has used and/or is using:

- Alcohol:
- Illegal Drugs:
- Tobacco:

SEXUAL RELATIONS:

Please describe any KNOWLEDGE OR SUSPICION you may have abouy whether your child has or is, sexually active:

LEGAL ISSUES:

If your child has ever had any "problems with the law", please describe:

SPECIFIC LEGAL ISSUES:

Also, specifically, please circle any of the following offenses your child has committed, and his/her age at the time:

OFFENSE	AGE
Truancy	
Running Away	
Stealing from home	
Stealing from outside home	
Robbery	
Frequent Fights	
Use of weapon in a fight	
Severe violence to peers	
Severe violence to adults	
Severe violence to parents	
Sexual assault	
Cruel to animals	
Vandalism	
Sexual Assault	

SPECIFIC LEGAL CONSEQUENCES:

Also, specifically, please circle whether your child has suffered from any of the following legal consequences, and give your child's age at the time, and the "reason" for the consequence.

CONSEQUENCE	AGE	REASON
Suspected in a crime		
Arrested		
Convicted		
Suspended Sentence		
Probation		
Community Service		
House Arrest		
Juvenile Detention		
Jail		

DEVELOPMENTAL HISTORY

PREGNANCY:

Did the child's mother have any PROBLEMS during pregnancy, labor delivery? Yes / No

Full term? Yes / No Number of Weeks Gestation: _____

Age of Mother: _____ and father: _____ at birth of child

Birth Weight: _____ Was the pregnancy planned? Yes / No

Name of pediatrician at birth: _____

How many times was mother pregnant before birth of this child? _____

How many times, if any, did mother suffer any miscarriages or abortions before birth of this child? ____

Was this child's pregnancy a "High Risk Pregnancy"? Yes / No

Why? _____

_____

How much weight did the mother gain during pregnancy? _____

SPECIFIC PROBLEMS:

Please circle any of the following problems, if they occurred during pregnancy, and give details:

PROBLEM	**DETAILS**
Hospitalization?	
Operations:	
X-ray studies?	
Medication use?	
Smoking or tobacco use? (how much) ?	
Alcohol Use? (how much) ?	
Drug Use? (how much) ?	
Eclampsia or Preeclampsia?	
Toxemia?	
Threatened Miscarriage?	
Premature Rupture of Membranes?	
Twins or Triplets?	
Weight Loss in the mother?	
High Blood Pressure?	
Depression in the mother?	
Excessive Vomiting?	
Bleeding or spotting?	
Rashes?	
Fevers or Injection?	
Kidney Trouble?	
Rh Factor Problem?	
Diabetes?	
Infections, colds, flu?	
Anemia	
Physical injury	
Measles	
Herpes	

AIDS	
Other illnesses in the mother?	

LABOR AND DELIVERY:

Please circle correct items below, and give details where needed:

Type of Labor: Spontaneous or Induced

Duration of Labor (hours)? _____

Fetal Distress? Yes / No If yes, what kind of distress? _____

Type of delivery? Vaginal vs. Caesarean vs. Forceps

Baby's Position: Normal (head first) vs. Breech

Complications:

- Hemorrhage
- Cord around baby's neck
- Meconium Staining
- Infant Injured during delivery
- Other problems during labor and delivery: _____

AFTER DELIVERY (POST-NATAL PERIOD):

Number of days infant in the hospital after delivery? _____
Numer of days mother in hospital after delivery? _____

SPECIFIC POST-NATAL PROBLEMS:

Please circle and give details about those post-natal problems experienced by this child:

POST-NATAL PROBLEMS	DETAILS
Jaundice	
Cyanosis (turned blue)	
Incubator Care	
Infections	
Breathing Problems	
"Hyaline Membrane Disease"	
Trouble Feeding?	
Other	

INFACNY PERIOD:

Please circle any of the following problems that were significant during the first few years of this child's life? Please give details to the side:

PROBLEM	DETAILS
Poor feeding	
Poor sleeping	
Too quiet, sleepy, lethargic	
Too floppy	
Too stiff	
Frequent ear infections	
Frequent accidents	
Frequent illnesses	
Hearing problems	
Visual problems	
Speech Problems	
Physical handicap	
Seizures	
High fevers	
Did not enjoy cuddling	
Was not calmed by being held or stroked	
Difficult to comfort	
Colic, excessive irritability or crying	
Excessive restlessness	
Difficult nursing (Breast or bottle fed)	
Frequent headbanging constantly into everything	
Frequent tantrums	
Very Fearful	
Very shy	
Very “clingy”	

STRESSFUL EVENTS

Please circle any of the stressful events listed below, that have occurred during your child’s life, and note the AGE of your child, when they occurred:

STRESSFUL EVENTS	AGE
Physical Abuse	
Sexual Abuse	
Psychological Abuse	
Neglect of any type	
Parent(s) abandoned child	
Parent died	
Parent seriously ill	
Sibling died	
Sibling seriously ill	
Grandparent died	
Death of relative close to child	
Parental separation	
Parental divorce	

Frequent family moves	
Serious family financial problems	
Prolonged or frequent absence of mother or father	
Relative or friend moved into home	
Other	

DEVELOPMENTAL MILESTONES

PAST ADVICE:

Has a professional ever told you your child suffered a "developmental delay"? Yes / No

If so, please describe WHO, WHEN, WHAT KIND?

	WHO	**WHEN**	**WHAT KIND OF DELAY**
1.			
2.			
3.			

SPECIFICS:

Please list the specific AGE at which your child FIRST accomplished the following skills. For those items that you cannot remember, please "check" EARLY, NORMAL, OR LATE.

DEVELOPMENTAL MILESTONE	**AGE**	**EARLY**	**NORMAL**	**LATE**
Walked without assistance				
Spoke first words				
Completed bowel and bladder training				
Smiled				
Sat without support				
Crawled				
Stood without support				
Said phrases				
Said sentences				
Bladder trained, day				
Bladder trained, night				
Bowel trained, day				
Bowel trained, night				
Fed self				
Rode tricycle				
Rode bicycle (without training wheels)				
Buttoned clothing				
Tied shoelaces				
Named colors				
Named coins				
Said alphabet in order				

Began to read				

COORDINATION:

Please rate (with check mark under "good, average, or poor") your child's current coordination on the following skills:

SKILL	GOOD	AVERAGE	POOR
Walking			
Running			
Throwing			
Catching			
Tying Shoelaces			
Buttoning			
Cutting with Scissors			
Writing			
Athletic Abilities			
Excessive number of accidents compared to other children			